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Department of Health and Hospitals

Louisiana Department of Health and Hospitals
Bayou Health Informational Bulletin 12-15
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Issue: Referral and Prior Authorization Policies

Amerigroup

Quick Reference: https://providers.amerigroup.com/QuickTools/Pages/PrecertificationLookup.aspx > Select "Louisiana" Market > Select "Medicaid/SCHIP/Family Care" Line of Business.

Applicable Definitions:

> **Referral** is the directing of a member/patient to a medical specialist by a provider (usually a PCP) or Amerigroup care coordinator/case manager.
>
> **Prior Authorization, termed "precertification"** by Amerigroup, is the process whereby Amerigroup determines the medical necessity and appropriateness of a given coverage request *before* the service is provided.

Referral Policy: Referral is not required to see an in-network specialist. However, some specialty and other services require precertification. See above quick reference for complete precertification information. Amerigroup encourages communication between PCPs and treating specialists for purposes of coordination of care; however, there are no specific guidelines that require specific documentation be exchanged.
Prior Authorization Policy: Refer to the Precertification Guidelines grid on page 49 of the Provider Manual https://providers.amerigroup.com/AGP%20Documents/LALA_CAID_Prov_Man.pdf

Referral and Prior Authorization Questions:
Provider Services Phone: 800-454-3730, Fax: 800-964-3627

Community Health Solutions

Quick Reference: http://www.louisiana.chsamerica.com/index.php?id-70

Applicable Definitions:

Referral – Written or verbal approval for a Member to seek and obtain services from a specialist or other provider when the PCP does not offer such service.

Prior Authorization – Written or verbal approval for a medically necessary service or procedure as defined by the Louisiana Medicaid State Plan.

Referral Policy: A blanket referral is provided through September 1, 2012 during the early implementation phase. The PCP can use 2475248 or any 7 digit referral number (cannot be all zeros or nines) for the blanket referral. Beginning September 2, 2012, a referral will be required to see a specialist or another PCP outside of the practice/group to whom the Member is assigned. Effective July 1, 2013 CHS-LA will require a referral for low level ER visits (CPT codes 99281 & 99282). Members may be referred to and see any Medicaid enrolled specialists; all specialists and hospitals are considered in-network. The referral can be provided by the PCP or can be obtained by calling CHS at 855-CHS-LA4U (855-247-5248).

Prior Authorization Policy: Prior Authorization Policy: Refer to CHS website at http://www.louisiana.chsamerica.com/documents/Procedure_Codes_Requiring_Prior_Auth.pdf for the list of services and procedures that require Prior Authorization or call 855-CHS-LA4U (855-247-5248) for more information.

Referrals and Prior Authorizations Questions:
Care Management Department Phone: 855-CHS-LA4U (855-247-5248)

LaCare

Quick Reference: http://lacarelouisiana.com/provider/resources/referrals/index.aspx

Applicable Definitions

> **Referral:** The process followed by a PCP and/or Specialist when needed medical care or services cannot be provided within the primary care office or when services outside the scope of his/her expertise are indicated.
>
> **Prior Authorization**: A determination made by LaCare or its representative to approve or deny payment for a service or course of treatment of a specific duration and scope prior to the provider's initiation of the requested service. The Prior Authorization process often involves a nurse and/or physician reviewing the request for medical necessity. This process may be initiated by contacting LaCare's Utilization Management Department.

Referral Policy: Referral is not required to see an in-network specialist. In addition, the following services do not require Referral, Prior Authorization, or Notification:

- In-network Specialists
- Emergency Room Services
- 30 Hour Observations, except for maternity which requires notification
- Low level plain films (X rays, EKGs)
- Dialysis
- Family Planning Services
- EPSDT Screening Services
- Women's Healthcare by In-Network Providers
- Continuation of covered services for a new member transitioning to the plan for the first 30 calendar days of continued services

- Vision Services (per VSP Guidelines); Contact Lenses are covered only when they are the only means of restoring vision
- Services rendered in a school based health clinic

Prior Authorization Policy: Prior authorization is required for out-of-network services. When out-of-network services are needed, the network provider should contact the Utilization Management Department for Prior Authorization. LaCare's Utilization Management Department Telephone Number is **888-913-0350**. If a non-Participating Provider is prior authorized, that provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **888-922-0007.**

For a comprehensive list of services requiring prior authorization, see http://lacarelouisiana.com/provider/resources/priorauth/index.aspx

Prior Authorization Questions:
LaCare Utilization Management Department Phone: 888-913-0350, Fax: 866-397-4522

Referral Questions:
Provider Services Phone: 877-922-0007

Louisiana Healthcare Connections (LHC)

Quick Reference: http://www.louisianahealthconnect.com/for-providers/prior-authorization/

Applicable Definitions

> **Referrals** are paper documents that originate with one provider (not the health plan) indicating that their permission is granted for the member (their patient) to see another provider, usually a specialist.
>
> **Prior Authorization** is an approval from the health plan (not the provider) for a service that the member needs. A prior authorization means that the approval is needed prior (before) the service is provided. (Some services require prior authorization from Louisiana Healthcare Connections in order for reimbursement to be issued).

Referral Policy: Referral is not required to see an in-network specialist. As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for LHC members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals *are not* required. To better coordinate a member's healthcare, Louisiana Healthcare Connections encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Prior Authorization Policy: http://www.louisianahealthconnect.com/files/2012/01/LA-Provider-Combo-Benefit_Prior-Auth-List_LHC_01202012_revised.pdf

Some services require prior authorization from LHC in order for the provider to be reimbursed. All out-of-network services require prior authorization. Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider by fax, phone, secure email, or secure web portal. LHC Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, NurseWise staff is available to answer questions about prior authorization.

Prior authorization should be requested at least seven calendar days before the scheduled service delivery date or as soon as need for service is identified. The PCP should contact the UM department via telephone, fax or through the LHC website with appropriate supporting clinical information to request an authorization. The fax number is **877-401-8175**.

Referral and Prior Authorization Questions
Call 866-595-8133 and ask to speak to Prior Authorization.

UnitedHealthcare (UHC)

Quick Reference: www.uhccommunityplan.com/assets/LA-2012-UHC-Prior-Authorization-List.pdf

Applicable Definitions

> **Referral** is the directing of members for services or procedures to be provided by another provider, typically a specialist, when those services are outside the scope of service for the directing provider. Typically referrals are given by the member's primary care physician.
>
> **Prior Authorization** is an approval from UnitedHealthcare for a service or procedure prior to the service being rendered for a member that is deemed medically necessary and meets the Louisiana Medicaid regulations as a covered service.

Referral Policy: Referral is not required for any covered service.

Prior Authorization Policy: UnitedHealthcare requires prior authorizations for certain covered services. For a list of services that require prior authorization, refer to the Benefits and Prior Authorization Grid on page 10 of the Provider Manual and the quick reference link provided above. All physicians, facilities and agencies providing services that require prior authorization should call the Prior Authorization Department at **866-604-3267** (available 24/7), in advance of performing the procedure or providing service(s) to verify UnitedHealthcare has issued an authorization number.

A Primary Care Physician or specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician or pharmacist reviews all cases in which the care does not appear to meet criteria or
guidelines which are adopted by UnitedHealthcare Community Plan's Medical Policy Committee. Decisions regarding
coverage are based on the appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded, nor receive incentives for issuing denials of coverage or service.

Responses to requests will be answered within two business days for standard requests, and within 72 hours for expedited requests.

Prior Authorization Questions:
Intake/Prior Authorization Team Phone: 866-604-3267, Fax: 877-271-6290 (Available 24/7)